STATE OF CALIFORNIA

APPLICATION FOR STATE LICENSE AS A NATUROPATHIC DOCTOR

ND-100 (Rev 01/08)

Department Of Consumer Affairs
Bureau Of Naturopathic Medicine
P.O. Box 980490, West Sacramento, CA 95798-0490
Telephone: (916) 574-7991 TDD: (916) 322-1700
Website: www.naturopathic.ca.gov

For Office Use Only:

Cashiering No. _____

Amt Rec'd: _____

APPROPRIATE FEE MUST ACCOMPANY THIS FORM
Make check payable to – Bureau of Naturopathic Medicine

(Please type or print clearly in ink)

1. NAME: Last First Middle

2. OTHER NAMES YOU HAVE USED (Include MAIDEN NAME)

3. BIRTH DATE: mo/day/yr	4. PLACE OF BIRTH: city/state/country	5. SOCIAL SECURITY NUMBER:**	6. GENDER ☐ Male ☐ Female

7. MAILING ADDRESS: Number and Street

City	State/Country	Zip Code

8. BUSINESS TELEPHONE *(with Area Code)* 9. HOME TELEPHONE *(with Area Code)*:

10. HAVE YOU EVER FILED AN APPLICATION FOR A NATUROPATHIC DOCTOR'S LICENSE IN CALIFORNIA? ..... **YES** ☐ **NO** ☐
*If YES, indicate date (mo/day/yr) and status:*_____

11. LIST QUALIFYING DEGREE IN NATUROPATHIC MEDICINE: 12. GRADUATION DATE: month & year

13. LIST ALL SCHOOLS WHERE PROFESSIONAL NATUROPATHIC MEDICAL EDUCATION WAS RECEIVED. FIRST ONE LISTED SHOULD BE THE SCHOOL ATTENDED FOR QUALIFYING DEGREE. *If additional space is needed, attach a supplement to this application. Submit official transcripts for each school attended as described in the instructions.*

COLLEGE / UNIVERSITY	CITY, STATE, COUNTRY	DATES OF ATTENDANCE	CREDITS / DEGREE EARNED

14. DO YOU INTEND TO FURNISH OR ORDER DRUGS (SCHEDULES III-V) AS A LICENSED NATUROPATHIC DOCTOR? ..... **YES** ☐ **NO** ☐
If YES, you must provide written evidence that you have completed the 48 hours of pharmacology training as described in the instructions.

15. NATUROPATHIC PHYSICIANS LICENSING EXAMINATION (NPLEX) ADMINISTERED BY NORTH AMERICAN BOARD OF NATUROPATHIC EXAMINERS (NABNE). *Provide the related documents as described in the instructions*.

a) HAVE YOU PASSED NPLEX PART I OR RECEIVED NABNE WAIVER? *If YES, complete 15.c).* ..... **YES** ☐ **NO** ☐
Indicate which one: ☐ Part I ☐ NABNE Waiver, explain _____

b) HAVE YOU PASSED NPLEX PART II? *If YES, complete 15.c)*..... **YES** ☐ **NO** ☐

c) LIST DATES AND LOCATION OF EXAMINATION(S). If additional space is needed, attach a supplement to this application.

Date examination taken (list exact date, mo/day/year)	Location
PART I	
PART II	

16. PRE-NPLEX – No longer applies as of January 1, 2008

17. REPORTING OTHER LICENSES/CERTIFICATES:

a) HAVE YOU EVER BEEN ISSUED A PROFESSIONAL LICENSE OR CERTIFICATE TO PRACTICE MEDICINE OR ANY HEALING ARTS (i.e., medical doctor, chiropractic, osteopathic, acupuncture, etc.) IN ANY STATE, TERRITORY, PROVINCE, FOREIGN COUNTRY, OR U.S. FEDERAL JURISDICTION? ..... **…YES** ☐ **NO** ☐

If YES, complete 17.b) and submit verification of licensure as described in the instructions.

b) LIST ALL YOUR MEDICAL, AND HEALING ARTS LICENSES/CERTIFICATES RECEIVED. (If additional space is needed, attach a supplement to this application.)

TYPE	STATE/COUNTRY	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

18. REPORTING DISCIPLINARY ACTIONS AGAINST LICENSE(S)/CERTIFICATE(S):

a) HAVE YOU EVER BEEN DENIED A PROFESSIONAL LICENSE/CERTIFICATE TO PRACTICE MEDICINE OR ANY HEALING ARTS (i.e., medical doctor, chiropractic, osteopathic, acupuncture, etc.) IN ANY STATE, TERRITORY, PROVINCE, FOREIGN COUNTRY, OR U.S FEDERAL JURISDICTION?..... **YES** ☐ **NO** ☐

b) HAVE YOU EVER HAD A PROFESSIONAL LICENSE/CERTIFICATE TO PRACTICE MEDICINE OR ANY HEALING ARTS (i.e., medical doctor, chiropractic, osteopathic, acupuncture, etc.) SUSPENDED, REVOKED, OR OTHERWISE DISCIPLINED?..... **YES** ☐ **NO** ☐

c) HAVE YOU EVER VOLUNTARILY SURRENDERED ANY SUCH LICENSE/CERTIFICATE?..... **YES** ☐ **NO** ☐

If YES to any question in 18.a) – c), attach your explanation and related documents as described in the instructions.

19. DO YOU HAVE ANY CONDITION THAT IN ANY WAY IMPAIRS OR LIMITS YOUR ABILITY TO PRACTICE NATUROPATHIC MEDICINE WITH REASONABLE SKILL AND SAFETY, INCLUDING BUT NOT LIMITED TO, ANY OF THE FOLLOWING? ..... **YES** ☐ **NO** ☐

If YES, check the appropriate box(es) below and attach your explanation and related documents as described in the instructions:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility;
- ☐ Alcohol or chemical substance dependency or addiction;
- ☐ Emotional, mental, or behavioral disorder; and/or
- ☐ Other (explain) _____

20. REPORTING PRIOR CONVICTION(S):

a) HAVE YOU EVER BEEN CONVICTED OF, PLED GUILTY TO, OR PLED NOLO CONTENDERE TO ANY VIOLATION (INCLUDE EVERY MISDEMEANOR OR FELONY) OF ANY LOCAL, STATE, OR FEDERAL LAW OF ANY STATE, TERRITORY, COUNTRY, OR U.S. FEDERAL JURISDICTION? ..... **YES** ☐ **NO** ☐

b) IS ANY CRIMINAL ACTION RELATED TO 20.a) PENDING? ..... **YES** ☐ **NO** ☐

(You do not need to include offenses prior to your 18th birthday or any traffic violations for which a fine of $500 or less was imposed.)

If YES to 20.a) or 20.b), attach your explanation and related documents as described in the instructions. YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

CERTIFICATION:

I declare under penalty of perjury under the laws of the State of California that all the information submitted on this form and on any accompanying attachments submitted is true and correct.

_____ _____

Signature of Applicant ***Date***

***Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c) (2) (c)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.*

Photo Area
Affix a recent 2" x 2"
(approximate size)
photograph here.

Photo must be of your
head and shoulder
area only.

INFORMATION COLLECTION AND ACCESS

Agency requesting information: California Department of Consumer Affairs, Bureau of Naturopathic Medicine, 400 R Street, Suite 3030, Sacramento, CA 95814, (916) 574-7991

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Sections 3630-3637 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Bureau Chief is the custodian of records.

APPLICANT DECLARATION/SIGNATURE and NOTARY

STATE OF_____

COUNTY OF _____

The applicant, _____, _____, being first duly
(print full name) (date of birth)
sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declares under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Naturopathic Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were produced without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions, schools, and/or organizations my references, personal physicians, employers (past, present, future), business and professional associates (past, present, future), and all government agencies (local, state, federal, or foreign) to release to the Bureau of Naturopathic Medicine (Bureau) of the California Department of Consumer Affairs or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Bureau in connection with this application; or any further or future investigation by the Bureau necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of Naturopathic Medicine. I further authorize the Bureau of Naturopathic Medicine or its successors to release to the organizations, individuals, or groups listed above any information, which is material to this application, or any subsequent licensure. I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGNATURE OF APPLICANT: _____
(sign full name, not initials)

Signed and sworn to before me this _____ **day of** _____ **,** _____**.**
(month) (year)

Notary Seal

_____
Signature of Notary Public

_____
Address

_____

My Commission expires _____